The Role of Power in Health Care Conflict: Recommendations for Shifting Toward Constructive Approaches : Academic Medicine

January 2021 - Volume 96 - Issue 1

- Previous Article
- Next Article

- **Outline**
  - Method
  - Research design and settings
  - Data collection
  - Data analysis
  - Results
  - Social bases of power involved in conflicts
  - Conflicts and impression management
  - Discussion
  - Acknowledgments:
  - References
  - Supplemental Digital Content
- **Images**
  - Slideshow
  - Gallery
  - Export PowerPoint file
- **Download**
  - PDF
  - EPUB
- **Cite**
  -
  - Copy
  - Export to RIS
  - Export to EndNote
- **Share**
  - Email
  - Facebook

- Twitter
- LinkedIn
- **Favorites**
- **Permissions**
- **More**
  - Cite
  - Permissions
  - Image Gallery

Research Reports

The Role of Power in Health Care Conflict: Recommendations for Shifting Toward Constructive Approaches

Bochatay, Naike PhD; Kuna, Ágnes PhD; Csupor, Éva MA; Pintér, Judit Nora PhD; Muller-Juge, Virginie MSc; Hudelson, Patricia PhD; Nendaz, Mathieu R. MD, MHPE; Csabai, Marta PhD; Bajwa, Nadia M. MD, MHPE; Kim, Sara PhD

Author Information

N. Bochatay is a postdoctoral scholar, School of Medicine, University of California, San Francisco, San Francisco, California; ORCID: https://orcid.org/0000-0002-6098-4262.

Á. Kuna is assistant professor, Department of Applied Linguistics and Phonetics, Eötvös Loránd University, Budapest, Hungary.

É. Csupor is a clinical psychologist, Department of Child and Adolescent Psychiatry, Pediatric Clinic, University of Szeged, Szeged, Hungary.

J.N. Pintér is associate professor, Department of Psychology of Counseling, Eötvös Loránd University, Budapest, Hungary; ORCID: https://orcid.org/0000-0002-2580-588X.

V. Muller-Juge is an associate specialist, School of Medicine, University of California, San Francisco, San Francisco, California; ORCID: https://orcid.org/0000-0002-2346-8904.

P. Hudelson is a medical anthropologist, Department of Primary Care, Geneva University Hospitals, and lecturer, Faculty of Medicine, University of Geneva, Geneva, Switzerland; ORCID: https://orcid.org/0000-0003-2601-7479.

M.R. Nendaz is professor and vice-dean, Department of Medicine and Unit of Development and Research in Medical Education, University of Geneva, Geneva, Switzerland; ORCID: https://orcid.org/0000-0003-3795-3254.

M. Csabai is professor and head of department, Department of Personality, Clinical, and Health Psychology, University of Szeged, Szeged, Hungary.

N.M. Bajwa is residency program director, Department of General Pediatrics, Children's Hospital, Geneva University Hospitals, and faculty member, Unit of Development and Research in Medical Education, University of Geneva, Geneva, Switzerland; ORCID: https://orcid.org/0000-0002-1445-4594.

S. Kim is research professor, Department of Surgery, School of Medicine, University of Washington, Seattle, Washington; ORCID: https://orcid.org/0000-0002-6623-5393.

Supplemental digital content for this article is available at https://links.lww.com/ACADMED/A993.

Funding/Support: This research was funded by the UW Medicine Patient Safety Innovations Program (PSIP) and George G. B. Blister Endowed Professorship in the Art of Communication with Peers and Patients and by the University of Geneva. Ágnes Kuna's research was supported by the Janos Bolyai Research Scholarship of the Hungarian Academy of Sciences and by the UNKP-19-4-ELTE-195 New National Excellence Program of the Ministry for Innovation and Technology.

Other disclosures: None reported.

Ethical approval: Ethical approval was granted by the University of Washington Human Subjects Office (July 25, 2013, Reference No. 45175) and waived by the State of Geneva Institutional Review Board (September 27, 2013) and by the Hungarian Inter-University Psychological Research Ethics Committee (January 30, 2015, Reference No. EPKEB 2015/1).

Correspondence should be addressed to Naike Bochatay, Division of Pediatric Critical Care Medicine, University of California, San Francisco, 550 16th St., Floor 5, San Francisco, CA 94143; telephone: (650) 382-7847; email: Naike.Bochatay@ucsf.edu.

Academic Medicine 96(1):p 134-141, January 2021. | DOI: 10.1097/ACM.0000000000003604

- Free
- SDC

Metrics

Abstract

Purpose

The combination of power and conflict is frequently reported to have a detrimental impact on communication and on patient care, and it is avoided and perceived negatively by health

care professionals. In view of recent recommendations to explicitly address power and conflict in health professions education, adopting more constructive approaches toward power and conflict may be helpful. This study examined the role of power in conflicts between health care professionals in different cultural contexts to make recommendations for promoting more constructive approaches.

Method

The authors used social bases of power (positional, expert, informational, reward, coercive, referent) identified in the literature to examine the role of power in conflicts between health care professionals in different cultural settings. They drew upon semistructured interviews conducted from 2013 to 2016 with 249 health care professionals working at health centers in the United States, Switzerland, and Hungary, in which participants shared stories of conflict they had experienced with coworkers. The authors used a directed approach to content analysis to analyze the data.

Results

The social bases of power tended to be comparable across sites and included positional, expert, and coercive power. The rigid hierarchies that divide health care professionals, their professions, and their specialties contributed to negative experiences in conflicts. In addition, the presence of an audience, such as supervisors, coworkers, patients, and patients' families, prevented health care professionals from addressing conflicts when they occurred, resulting in conflict escalation.

Conclusions

These findings suggest that fostering more positive approaches toward power and conflict could be achieved by using social bases of power such as referent power and by addressing conflicts in a more private, backstage, manner.

Hospital teams are structured by professions and hierarchies that are associated with statuses. The differences in statuses create power differentials between individuals.[1,2] Power can be defined as "having influence or control over the beliefs, behaviors and values of individuals, groups or institutions."[3] As such, power is inherently a social construct; it requires individuals to interact with one another under an agreement (often implicit) that some individuals will exert power over others, who will carry out tasks that they would not have engaged in otherwise.[4–6] To explain this phenomenon, French and Raven developed a theory of social power and identified 6 resources that individuals draw upon to influence others.[7,8] These resources, referred to as social bases, arise from formal positions and personal traits.[7,8] The 6 resources are (1) position, or legitimate power associated with one's status or title (e.g., attending physician, nurse manager); (2) expertise, or individuals' specialized knowledge on a given topic (e.g., cardiologist); (3) information, which

individuals can use to persuade others to act (e.g., a bedside nurse's observation of a patient demonstrating symptoms); (4) reward, or the ability to offer benefits in exchange for compliance (e.g., recommendation for formal recognition); (5) coercion, when individuals have the ability to force others to act in a specific way (e.g., requiring individuals to work beyond the end of a shift); and (6) referent or charisma, which refers to the ability to inspire others through confidence and warmth (e.g., supporting team members during challenging patient care situations).[7,8]

Power distance, the perception of unequal statuses between individuals,[9] can have negative effects on interprofessional team dynamics.[10] The literature on teamwork in health care reports that power differentials can lead to conflicts,[11–13] which are defined as the perception of differences, discrepancies, and incompatible goals among team members.[14] Health care professionals have high tendencies to avoid conflicts and to view them negatively.[13] Yet power and conflict are rarely explicitly addressed in health professions education and in efforts to improve collaboration.[15,16] Most research on conflicts in health care stresses their detrimental impact on communication and on patient care.[17–21] In contrast, constructive approaches view conflicts as a source of organizational resilience.[22,23] Conflicts may provide opportunities to clarify misunderstandings, to learn from others' perspectives, and to innovate.[24–26] Similarly, power differentials can serve a constructive purpose: They clarify roles and responsibilities and provide guidance to engage with those with different degrees of power. For example, a junior resident may refer to a clinical supervisor, who has both positional and expert power, when the resident is unsure about a patient diagnosis and needs help with patient management. Determining responsibilities and authority becomes more important in team-based care where coordination of work and communication are required, even though team members may not know each other, as a result of shifts and rotations.[27]

Given the structure of hospital teams,[1,2] there is an opportunity to use power and conflict constructively instead of viewing them negatively, especially in view of recent recommendations to explicitly acknowledge them in health professions education.[15] Additionally, though perceptions of power and conflict vary depending on the culture,[28–31] there is limited understanding of how these perceptions vary in the context of hospital teams. In this article, we use the social bases of power to examine the role of power in conflicts between health care professionals in different cultural contexts. Our aim is to extend the understanding of the role of power in health care conflict and to make recommendations for promoting a more constructive approach to power and conflict in health care.

Method

Research design and settings

We conducted qualitative exploratory research on health care professionals' experiences of conflicts in different cultural settings. Most qualitative research in health professions education focuses on single institutions, limiting the relevance of results to other settings.[32,33] We interviewed professionals working at health centers in 3 countries: 2 academic medical centers and a community-based hospital affiliated with the clinical enterprise of the University of Washington (UW Medicine) in the United States; the Geneva University Hospitals in Switzerland, which provides a range of services from primary outpatient clinics to tertiary care; and the University of Szeged Medical Center and 3 regional hospitals and primary care services in Hungary.

We selected these settings because they are both similar and different. The United States and Switzerland have high costs of care[34,35] and relatively similar health insurance systems and managed care.[36,37] By contrast, Hungary has low cost of care and state-funded universal health coverage.[38] There, a gratuity system referred to as parasolvency inherited from the socialist era creates competition between health care professionals who want to ensure that they receive more than their colleagues.[39] Health professions education differs between the settings, as it is more structured in the United States than in Switzerland and Hungary. However, health professions education models from the United States highly influence Switzerland and Hungary.[40,41] Of particular relevance to this article, power distance, defined as perceived differences in statuses between individuals,[9] tends to be low in the United States,[42] intermediate in Switzerland,[43] and high in Hungary.[44,45] In each country, a local team conducted the research with the aim of identifying sources and consequences of conflicts and then published key findings.[46–48] In this article, we report findings from separate analyses of the data, focusing on the social bases of power involved in conflicts.

Data collection

The U.S. team developed the research protocol and the Swiss and Hungarian teams then adapted it to their local contexts and translated the interview guide for language and conceptual equivalence.[49] Each team obtained IRB approval from local ethics committees.

The research teams randomly sampled health care professionals directly involved in patient care, using lists of staff members at each health center included in this study. Eligible participants in the United States were physicians, nurse practitioners, physician assistants, nurses, and other health workers, and in Switzerland and Hungary, physicians and nursing professionals, as the other professional groups did not exist there. We invited participants from a variety of settings (e.g., inpatient, outpatient), specialties (e.g., internal medicine, surgery), and services (e.g., primary care). We contacted sampled participants by telephone and email to request an interview and conducted all interviews in person or on the phone. In total, we conducted 249 interviews: 92 in the United States (July to December 2013), 82 in

Switzerland (November 2014 to February 2016), and 75 in Hungary (February 2015 to February 2016). We provide further details of study participants' professional background in Table 1. Because some participants shared several experiences, we collected 367 conflict stories.

Professional group	Research site			
	United States	Switzerland	Hungary	Total
Hospital leaders	13	0	0	13
Physicians (residents, fellows, attending physicians)	37	43	51	131
Nurse practitioners and physician assistants	3	0	0	3
Nursing professionals (registered nurses, nurse supervisors, certified nursing assistants)	39	39	24	102
Total	92	82	75	249

[a]Semistructured interviews were conducted from 2013 to 2016 with 249 participants, who relayed 367 stories of conflicts. Participants worked at health centers in 3 countries: 2 academic medical centers and a community-based hospital affiliated with the clinical enterprise of the University of Washington (UW Medicine) in the United States; the Geneva University Hospitals in Switzerland, which provides a range of services from primary outpatient clinics to tertiary care; and the University of Szeged Medical Center and 3 regional hospitals and primary care services in Hungary.

Table 1:
Number of Participants by Professional Group and Research Site, Study of Experiences of Conflicts Between Health Care Professionals in Different Cultural Contexts, 2013–2016[a]

The interviewers had prior experience with qualitative research (they included N.B., É.C., V.M.-J., P.H., and S.K.; other interviewers are listed in the Acknowledgments). The interviewers had a deep understanding of the hospital environment without directly working in it, which was important to ensure that participants would feel comfortable discussing a topic as sensitive as conflicts with coworkers. In the United States, interviewers observed several interviews conducted by the primary researcher (S.K.) and discussed their thoughts on the process before they started interviewing participants themselves. In Switzerland and Hungary, interviewers conducted pilot interviews with clinicians who did not participate in the study to test the interview guide, become more familiar with it, and receive advice from other interviewers. Throughout the data collection process, they also listened to all interviews to give feedback on interviewing techniques and to control for individual differences between interviewers. Supplemental Digital Appendix 1 (https://links.lww.com/ACADMED/A993) provides an overview of our guiding questions. We asked participants to discuss conflicts they had experienced or witnessed with coworkers. We prompted participants to describe what had triggered the conflict, what the consequences were, and how they had managed the conflict. In the United States, the team took extensive notes during the interviews because audio recording was not allowed by the IRB. In Switzerland and Hungary, the teams audiotaped interviews and transcribed them.

Data analysis

The research teams at each site first analyzed the data they had collected, focusing on the sources and consequences of conflicts between health care professionals. They performed these analyses with a combination of Microsoft Excel and Word in the United States (Microsoft Corporation, Redmond, Washington) and ATLAS.ti version 7.5 in Switzerland and Hungary (ATLAS.ti Scientific Software Development GmbH, Berlin, Germany). They published the findings from these analyses separately.[46–48] In October 2016, we held a research symposium in Szeged, Hungary, during which we identified power as a critical

element that deserved further examination across sites. More specifically, we wanted to understand which social bases of power individuals involved in conflicts drew upon and whether these bases differed between research sites and cultural contexts. For this article, we adopted a directed approach to content analysis,[50] which means that we used the social bases of power (positional, expert, informational, reward, coercive, referent[7,8]) as initial codes to extend our understanding of the role of power in conflicts. First, 2 researchers at each site (S.K. and N.M.B. in the United States, N.B. and M.R.N. in Switzerland, Á.K. and J.N.P. in Hungary) screened each conflict story to identify if power in a broad sense was involved. They excluded stories that tended to arise from interpersonal issues, such as 2 individuals from the same professional group and the same hierarchical level who disliked each other. Together, we then identified social bases of power in each story and recorded them in a Microsoft Excel spreadsheet, along with an English summary of each conflict story included in this analysis. Some stories had several social bases of power involved, but we usually identified one as being more prominent in participants' discourses. For example, a resident described a conflict in which she perceived that her fellow had used his higher position in the hierarchy to ridicule her instead of teaching her. While the resident mentioned that the fellow sometimes made her perform tasks that were outside of her expertise (coercive power), the main problem was the difference in status (positional power). We used the Excel spreadsheet to compare conflict stories and to analyze the prevalence of each social basis of power at each site. We used the English summaries to immerse ourselves in the data and to start making sense of them. In doing so, we noticed that participants emphasized power when conflicts had occurred in front of others. Directed content analysis allows researchers to identify codes that go beyond the initial framework used,[50] so we added 2 codes informed by impression management. This theory examines individuals' strategies for presenting themselves in front of others through the metaphor of the performance stage: Frontstage interactions are more formal and hierarchical, while backstage interactions are more spontaneous and less hierarchical.[51] We added codes to distinguish between frontstage conflicts, which had occurred in front of an audience (e.g., coworkers, patients), and backstage conflicts, where health care professionals involved were the only witnesses of the conflict. We also provided further descriptions of these frontstage and backstage interactions for each conflict story in the Excel spreadsheet.

Throughout the data analysis process, we had extensive meetings to discuss the data in a more nuanced way. In these meetings, we usually involved interviewers who had a deep knowledge of the data (e.g., N.B., S.K., É.C., P.H., V.M.-J.) and clinicians who were familiar with the hospital environment (e.g., N.M.B., M.R.N.) to discuss data interpretation and ensure that our findings were consistent with clinicians' experiences.

Results

Approximately half of the conflict stories we collected across sites involved power (194/367, or 53%), as Table 2 shows. Conflict involved power in 56/146 stories in the United States

(38.5%) and 50/130 in Switzerland (38.5%). By contrast, almost all conflict stories involved power in Hungary (88/91, or 97%). In spite of these differences, the social bases of power tended to be comparable across sites and included positional, expert, and coercive power (Table 2). Our findings therefore focus on these 3 social bases; we provide an illustrative quote or excerpt from our notes for each social base in Table 3.

Characteristic	Research site			
	United States	Switzerland	Hungary	Total
Conflict stories				
Interviews, no.	92	82	75	249
Conflict stories, no.	146	130	91	367
Conflict stories involving power, no. (%)	56 (39)	50 (39)	88 (97)	194 (53)
Social bases of power in conflict stories involving power				
Positional, no. (%)	38 (68)	24 (48)	51 (58)	113 (58)
Expert, no. (%)	10 (18)	12 (24)	12 (14)	34 (17)
Informational, no. (%)	1 (2)	0 (0)	8 (9)	9 (5)
Reward, no. (%)	0 (0)	0 (0)	1 (1)	1 (1)
Coercive, no. (%)	7 (12)	12 (24)	15 (17)	34 (17)
Referent, no. (%)	0 (0)	2 (4)	1 (1)	3 (2)
Impression management in conflict stories involving power				
Frontstage conflict stories, no. (%)	51 (91)	41 (82)	66 (75)	158 (82)
Backstage conflict stories, no. (%)	5 (9)	9 (18)	22 (25)	36 (19)

[a]Semistructured interviews were conducted from 2013 to 2016 with 249 participants, who relayed 367 stories of conflicts. Participants worked at health centers in 3 countries: 2 academic medical centers and a community-based hospital affiliated with the clinical enterprise of the University of Washington (UW Medicine) in the United States; the Geneva University Hospitals in Switzerland, which provides a range of services from primary outpatient clinics to tertiary care; and the University of Szeged Medical Center and 3 regional hospitals and primary care services in Hungary. Percentages are rounded to the nearest whole number and may not add up to 100%.

Table 2:

Conflict Stories Involving Power, Study of Experiences of Conflicts Between Health Care Professionals in Different Cultural Contexts, 2013–2016[a]

Characteristic	Illustrative quote or excerpt from research notes
Social bases of power[7,8]	
Positional (power associated with one's status)	There are a lot of tensions due to a kind of caste system, with subordination and superiority associated with different teams. For example, the resident who works on the famous professor's team gets a lot more opportunities and training than any other resident. (Quote, Physician 26, Hungary)
Expert (power associated with one's area of expertise)	We had a patient on the floor; he had a cirrhosis and went into septic shock. We thought that the shock could have been treated in the ICU, but the ICU refused to take him because of his cirrhosis due to his alcohol consumption. Of course, they could not treat the cirrhosis, but they could have treated the infection. We had a lot of conflicts with the ICU about this patient. (Quote, Physician 3, Switzerland)
Informational (power associated with information that one has)	The participant is an intensive care physician and has learned that nurses on the floor often know when patients need to be transferred to the ICU. However, physicians on the floor refuse to listen to nurses. The participant often goes to the charge nurse on the floor to see which patients need to be transferred, based on nurses' assessments. (Excerpt from research notes, Physician 8, United States)
Reward (power associated with the ability to compensate compliance)	I should have been promoted a long time ago, but it only happened this year. And after so much time waiting for it and working really hard, all I got from the head of my institute was a text message to say congratulations. That's it. I was very disappointed. (Quote, Physician 8, Hungary)
Coercive (power associated with the ability to make individuals act in a specific way)	The surgeon ordered blood work when there had already been 3 blood draws with similar results. She went to the nurse and yelled at her in front of everyone in the operating room, asking why the blood tests were not returned. The family member looked at the nurse mortified and later asked whether she was okay. The nurse thought that they should take this conversation somewhere else, but she walked away to get the blood test done. (Excerpt from research notes, Nurse 24, United States)
Referent (power associated with one's charisma and ability to inspire)	As junior residents, we really struggled at the beginning of our rotation because we are the reference center for all of Switzerland, so the attendings had really high expectations. They wanted us to go see them if we had problems, but that's hard. They are the bosses and they have such high expectations.… We didn't want them to be disappointed with us. (Quote, Physician 52, Switzerland)
Impression management[51]	
Frontstage (presenting oneself formally, as if in front of an audience)	An attending came in with a team of residents and started going over daily care. At some point, she stopped everything and asked why the patient's legs were not wrapped. She said, "This is part of a protocol. Do we need to do special training with you?" I felt terribly put on the spot in front of patient and family and all the doctors. She should have asked the question out of earshot of the patient. (Excerpt from research notes, Nurse 21, United States)
Backstage (presenting oneself less formally, as if in more private spaces)	The attending was only interested in his research and did not play his role in the clinic.… Patients would go to him to ask about their diagnosis, and he would be dismissive and act as if it didn't matter. That got me really mad, so at some point, I took him to my office, just the 2 of us, and I said, "Listen, there are things you can't do! You can't talk to patients like that!" (Quote, Nurse 40, Switzerland)

[a]Semistructured interviews were conducted from 2013 to 2016 with 249 participants, who relayed 367 stories of conflicts. Participants worked at health centers in 3 countries: 2 academic medical centers and a community-based hospital affiliated with the clinical enterprise of the University of Washington (UW Medicine) in the United States; the Geneva University Hospitals in Switzerland, which provides a range of services from primary outpatient clinics to tertiary care; and the University of Szeged Medical Center and 3 regional hospitals and primary care services in Hungary.

Table 3:

Illustrative Quotes or Excerpts From Research Notes for All Social Bases of Power and Impression Management From Conflict Stories Involving Power, Study of Experiences of Conflicts Between Health Care Professionals in Different Cultural Contexts, 2013–2016[a]

In the majority of the stories, participants presented themselves as the victims of the situation and reported conflicts that had occurred with individuals who had greater power. Furthermore, most conflicts involving power were frontstage conflicts that occurred before an audience (158/194, or 81.5%) (Table 2).

Social bases of power involved in conflicts

Among conflict stories involving power, the majority involved positional power (113/194, 58%). These stories occurred within professions (intraprofessional) or between professions (interprofessional). Intraprofessional conflicts often involved participants' supervisors, when participants perceived that supervisors had used their higher status inappropriately. For example, a physician reported how the head of her department took over her patients:

Quite often, when I have patients who are hospitalized and are scheduled for an operation the next day, the head of my department goes to my patients and starts grilling them. He asks why they picked me as a doctor and insists that he should do the operation himself since he is head of the department. (Physician 24, Hungary)

Interprofessional conflicts involving positional power also included other social bases of power. For instance, conflicts often occurred between junior residents and experienced nurses. As physicians, junior residents had more positional power that enabled them to place orders for patients. Nurses, however, had greater expert power and resisted residents' orders, requiring residents to ask for support from someone with both positional and expert power:

This nurse is very experienced and he doesn't like taking orders from anyone. At some point, my attending really had to step in and say, "Okay, that's enough! We do as we decided and that's it. I'm the one who wrote the order." (Resident 61, Switzerland)

Conflicts in which expert power was the main social basis took place when professionals from different specialties felt as though they were competing against each other:

The nurse describes a patient situation where multiple teams were involved. One consult team suggested a diagnosis, but the primary team refused to consider it. After much debate, the primary team decided to try the consult team's suggested treatment. When the patient got better, the primary team assumed that the patient was responding to their treatment and discontinued the medication suggested by the consult team. The patient's state significantly deteriorated. The nurse observed: "If they had worked together, the right treatment could have been given and maybe decreased the amount of risk and discomfort to the patient." (Nurse 22, United States)

Conflicts involving coercive power often revolved around shifts. As an example, a resident described how a scrub nurse had been forced to stay after the end of his shift because the surgeon did not want him to leave during a surgery:

The surgeon stopped the scrub nurse from handing the patient over and leaving. He said: "You have to stay; it's a complicated surgery." The scrub nurse was kind of locked in with the surgeon, in the sterile field, without being able to walk away. So the surgeon really gets to decide. That can be stressful. No one wants to upset surgeons because during surgeries, surgeons have the most power in the operating room. (Resident 63, Switzerland)

Conflicts and impression management

At all research sites, participants spontaneously reported that conflicts had been worsened by the presence of an audience. These frontstage conflicts occurred in the operating room, at interprofessional meetings, or during morning rounds. They also took place in public spaces such as hallways or patients' rooms where patients and families were present. A resident described a situation where his patient's parents witnessed a conflict between him and a nurse:

The pediatric resident was talking to his patient's parents about a procedure to repair facial laceration. The nurse came in and said, "You need to wear a mask and gown." The nurse added, "You have to stop doing what you're doing now and put on a mask." The resident went out, put on the mask and gown, and went back to talk to the parents. Later that day, the resident went to the nurse to share his perspective. He explained that he was trying to speak with the family and build trust prior to performing the procedure. (Resident 10, United States)

In this situation, the nurse's expert power and her role as an advocate for her patient superseded the resident's positional power because of the presence of the family. Although the resident was unhappy about the way the nurse had interrupted his discussion with the family, he waited until they were backstage, away from others, to try and resolve the conflict. When conflicts involving power occurred frontstage, participants often avoided discussing them, leaving the conflicts unaddressed. They did so for collegial reasons because they did not want to undermine their coworkers in front of others. A fellow described a situation where he thought that a colleague put too much pressure on residents at morning report. However, in spite of disagreeing with his colleague, this fellow did not step in:

We were at morning report, there were lots of people there: anesthesiologists, midwives, nurses, residents, students. That's not the right time to discuss a colleague's attitude; we can't start arguing at morning report…. You see, out of respect for my colleague, I can't start complaining about him. I can't say anything if there's a nurse with us; it wouldn't be fair on my colleague. (Physician 41, Switzerland)

However, participants reported speaking up and addressing conflicts that occurred backstage. These conflicts involved rapid discussions such as on the telephone:

I was on night shift, and there was a patient whose situation deteriorated. The patient's doctor was not working that night, but another doctor was on duty and he prescribed treatments for the patient. Then, the patient's doctor called me because the doctor on duty

had told him about the issues, so he called and told me to administer a different treatment. But I said no, I won't give anything that is just prescribed like that on the phone. (Nurse 54, Hungary)

Discussion

Using French and Raven's social bases of power,[7,8] we explored the role of power in conflicts between health care professionals in the United States, Switzerland, and Hungary. In doing so, we aimed to understand why power and conflict are often viewed negatively in health care to make recommendations to support a shift toward more constructive approaches. We found that most conflict stories shared in Hungary involved power (88/91, or 97%), which may reflect the high power distance in this context as a result of the socialist era.[39,44,45] By contrast, conflict stories shared in the United States and Switzerland did not always involve power. When power was involved in conflicts, the social bases of power were similar across sites and predominantly included positional, expert, and coercive power.[7,8] Conflicts involving power often occurred in front of an audience, in which case participants tended to avoid addressing them. When conflicts occurred backstage, participants reported speaking up and managing conflicts more proactively.

Our findings reveal several problems associated with power and conflict in health care. Positional power was prominent in the conflict stories, representing the main social basis of power. This finding points to difficulties caused by rigid hierarchies in health care. Because health care professionals undergo extensive periods of training, they remain learners for several years after the completion of their degree. This situation may create tensions when different social bases of power intersect, such as when individuals with greater positional power (e.g., junior residents) give orders to individuals with more expert power (e.g., experienced nurses).[52,53] Conflicts between professionals from different specialties often involved expert power. These conflicts were triggered by different degrees of perceived control, influence, and authority associated with specialties.[54] Conflicts around work hours and vacations tended to involve coercive power. Health care delivery is organized into shifts and rotations to provide continuity of care[55]; when participants perceived that they had to stay beyond their shift for invalid reasons, they experienced it as coercive power.

We also found that conflicts in which power played a role often occurred in front of an audience. Health care requires professionals from multiple specialties to engage in team-based care.[27,56] This means that health care professionals often perform their work in front of others, including patients and their families. Nurses at times drew on their expert power and their role as patient advocates to address frontstage conflicts, but most participants reported that these conflicts posed major hurdles to collaboration. Frontstage conflicts were often left unresolved, which could lead to escalating conflicts or trigger new conflicts.[46,57] However, we found that participants perceived backstage conflicts as nuisances associated with daily work that were rapidly solved through discussions or speaking up.

Based on our findings, we propose several recommendations to move from viewing power and conflict negatively and to adopt more constructive approaches. These recommendations align with recent discourses on teamwork in health care, which support open discussions of power and conflicts to improve collaboration.[15]

First, we found that the main social bases of power involved in conflicts were predominantly positional, expert, and coercive power and that our participants viewed them negatively. Supervisors and professionals in higher positions might benefit from openly acknowledging that they have more power associated with greater decisional authority and inviting everyone on the team to share ideas (e.g., using sentences such as, "I am aware that it might seem difficult to challenge my decisions because I am your supervisor, and I want you to feel empowered to speak up and ask questions"). They could also draw on other social bases such as referent power, which represents charisma and the ability to inspire.[7,8] Individuals could draw on their referent power by modeling the positive behaviors they wish to encourage in team members, such as admitting mistakes and uncertainty and seeking advice from others instead of imposing decisions.[58] This shift would also support psychological safety, which refers to the perception that individuals can act without fear of negative consequences.[59] Psychological safety has been associated with decreased power distance and improved perceptions of team dynamics.[10] Given that power tended to be highly intertwined with conflicts in Hungary, where perceptions of power distance are high,[44,45] fostering psychological safety there may contribute to creating a respectful and inclusive environment.

Second, interprofessional education (IPE) may be used to decrease the potentially negative impact of positional, expert, and coercive power on team dynamics. Power and conflict are rarely explicitly discussed in IPE,[16] yet IPE provides a unique opportunity to equip learners with conflict management and negotiation skills. At the undergraduate level, IPE can prepare learners to navigate work environments in which individuals have different degrees of authority, experience, and expertise.[60] At the postgraduate level, existing trainings such as interprofessional mock codes may be used to increase awareness of the potentially negative effects of positional, expert, and coercive power on team dynamics; to discuss conflict; and to practice the use of positive social bases of power such as referent power.

Third, efforts to promote constructive approaches to power and conflicts could target collaboration champions who are eager to develop better collaboration skills.[15]

Fourth, our findings suggested that frontstage conflicts were detrimental to clinical work and were often left unaddressed, whereas backstage conflicts allowed health care professionals to address conflicts more readily. To foster more constructive approaches to power and conflict, health care professionals may opt to hold conversations around conflict in more private locations, such as offices, to discuss disagreements.

Our study has several limitations. Because we did not specifically ask participants to talk about power, future research could focus on the interplay of power and conflict more deeply by prompting participants to discuss conflicts in which power was a key component. In addition, examining the link between power distance and frontstage or backstage handling of conflicts may provide new insights into power differentials. Another limitation is that as we mentioned in our results, most participants shared conflict stories in which they were in a perceived lower power position: They tended to describe themselves as the victims of the conflict. Although this finding points to the entrenched hierarchies in health care, it may also indicate participants' impression management during the interview.[51] Interviewing can generate rich insights into participants' experiences. It is, however, also associated with power imbalances between researchers and participants.[61] Although we paid attention to interviewers' backgrounds to ensure that they had no working relationships with participants, it is possible that participants wanted to make a positive impression on interviewers. Sharing conflict stories in which they felt victimized rather than in which they used power to impose their opinion on others may have been easier. Further research is needed to understand how those with more social power experience conflicts. Finally, this research was conducted in a limited number of settings and with limited professional groups. Extending the research to other groups, such as midwives or physical therapists, who have varying degrees of power depending on the patient care situation and on the country, may yield rich results.

Power and conflict are frequently reported to have a detrimental impact on team communication and on patient care[10,12,18,19,21] and tend to be avoided topics in health care.[13] Because there is a need to explicitly address power and conflict in health professions education,[15] we explored the role of power in health care conflict across cultural contexts to shift toward more constructive approaches. We identified key reasons why power and conflict are viewed negatively, which include perceived misuse of individuals' position, unequal statuses between professions and specialties, and difficulties associated with shifts and work hours. Another reason is the frequent presence of an audience, such as supervisors, coworkers, patients, and families, in health care. Our results suggest that fostering more positive approaches toward power and conflict could be achieved by using social bases of power such as referent power and by addressing conflicts backstage in a more private manner.

Acknowledgments:

The authors thank all study participants for entrusting the research teams with their experiences. The authors acknowledge the invaluable help of interviewers Isaac Bohannon, Lindsay Boyd, Elise Frans, Sarah Shannon, Stéphane Cullati, Rózsa Havancsák, Orsolya Szabó, Edina Katona, and Melinda Látos. In addition, Hanna Dasgupta, Noëlle Junod Perron, Katherine Blondon, Pierre Chopard, Nu Vu, Georges Savoldelli, and Fabienne Maître contributed to the study.

References

1. Kreindler SA, Dowd DA, Dana Star N, Gottschalk T. Silos and social identity: The social identity approach as a framework for understanding and overcoming divisions in health care. Milbank Q. 2012;90:347–374.

- Cited Here |
- Google Scholar

2. Hall P. Interprofessional teamwork: Professional cultures as barriers. J Interprof Care. 2005;19(suppl 1):188–196.

- Cited Here |
- Google Scholar

3. Kuper A, Veinot P, Leavitt J, et al. Epistemology, culture, justice and power: Non-bioscientific knowledge for medical training. Med Educ. 2017;51:158–173.

- Cited Here |
- Google Scholar

4. Parsons T. On the concept of political power. Proc Am Philos Soc. 1963;107:232–262.

- Cited Here |
- Google Scholar

5. Dahl RA. The concept of power. Syst Res. 1957 (2007)2:201–215.

- Cited Here |
- Google Scholar

6. Hogg MA. A social identity theory of leadership. Pers Soc Psychol Rev. 2001;5:184–200.

- Cited Here |
- Google Scholar

7. French JRP, Raven BH. Cartwright D, ed. The bases of social power. In: Studies in Social Power. 1959:Ann Arbor, MI: Institute for Social Research; 150–167.

- Cited Here

8. Raven BH. The bases of power and the power/interaction model of interpersonal influence. Anal Soc Issues Public Policy. 2008;8:1–22.

- Cited Here |
- Google Scholar

9. Bochner S, Hesketh B. Power distance, individualism/collectivism, and job-related attitudes in a culturally diverse work group. J Cross-Cult Psychol. 1994;25:233–257.

- Cited Here |
- Google Scholar

10. Appelbaum NP, Lockeman KS, Orr S, et al. Perceived influence of power distance, psychological safety, and team cohesion on team effectiveness. J Interprof Care. 2020;34:20–26.

- Cited Here |
- Google Scholar

11. Janss R, Rispens S, Segers M, Jehn KA. What is happening under the surface? Power, conflict and the performance of medical teams. Med Educ. 2012;46:838–849.

- Cited Here |
- Google Scholar

12. Bochatay N, Bajwa NM, Blondon KS, Junod Perron N, Cullati S, Nendaz MR. Exploring group boundaries and conflicts: A social identity theory perspective. Med Educ. 2019;53:799–807.

- Cited Here |
- Google Scholar

13. Eichbaum Q. Collaboration and teamwork in the health professions: Rethinking the role of conflict. Acad Med. 2018;93:574–580.

- Cited Here |
- Google Scholar

14. Boulding KE. Conflict and Defense: A General Theory. 1963. New York, NY: Harper & Row.

- Cited Here

15. Paradis E, Whitehead CR. Beyond the lamppost: A proposal for a fourth wave of education for collaboration. Acad Med. 2018;93:1457–1463.

- Cited Here |
- Google Scholar

16. Paradis E, Whitehead CR. Louder than words: Power and conflict in interprofessional education articles, 1954-2013. Med Educ. 2015;49:399–407.

- Cited Here |
- Google Scholar

17. Appelbaum NP, Dow A, Mazmanian PE, Jundt DK, Appelbaum EN. The effects of power, leadership and psychological safety on resident event reporting. Med Educ. 2016;50:343–350.

- Cited Here |
- Google Scholar

18. Beament T, Mercer SJ. Speak up! Barriers to challenging erroneous decisions of seniors in anaesthesia. Anaesthesia. 2016;71:1332–1340.

- Cited Here |
- Google Scholar

19. Okuyama A, Wagner C, Bijnen B. Speaking up for patient safety by hospital-based health care professionals: A literature review. BMC Health Serv Res. 2014;14:61.

- Cited Here |
- Google Scholar

20. Cullati S, Bochatay N, Maitre F, et al. When team conflicts threaten quality of care: A study of health care professionals' experiences and perceptions. Mayo Clin Proc Innov Qual Outcomes. 2019;3:43–51.

- Cited Here |
- Google Scholar

21. Rosenbaum L. Divided we fall. N Engl J Med. 2019;380:684–688.

- Cited Here |
- Google Scholar

22. Hackman JR. Leading Teams: Setting the Stage for Great Performances. 2002. Boston, MA: Harvard Business School Press.

- Cited Here

23. Eisenhardt KM, Kahwajy JL, Bourgeois LJ 3rd. How management teams can have a good fight. Harv Bus Rev. 1997;75:77–85.

- Cited Here |
- Google Scholar

24. Vandevliert E, Kabanoff B. Toward theory-based measures of conflict-management. Acad Manage J. 1990;33:199–209.

- Cited Here |
- Google Scholar

25. Oxenstierna G, Magnusson Hanson LL, Widmark M, et al. Conflicts at work—The relationship with workplace factors, work characteristics and self-rated health. Ind Health. 2011;49:501–510.

- Cited Here |
- Google Scholar

26. Tekleab AG, Quigley NR, Tesluk PE. A longitudinal study of team conflict, conflict management, cohesion, and team effectiveness. Group Organ Manage. 2009;34:170–205.

- Cited Here |
- Google Scholar

27. Paradis E, Pipher M, Cartmill C, Rangel JC, Whitehead CR. Articulating the ideal: 50 years of interprofessional collaboration in medical education. Med Educ. 2017;51:861–872.

- Cited Here |
- Google Scholar

28. Hofstede GH, Hofstede GJ, Minkow M. Cultures and Organizations: Software of the Mind: Intercultural Cooperation and Its Importance for Survival. 2010. 3rd ed. New York, NY: McGraw-Hill.

- Cited Here

29. Meyer E. The Culture Map: Breaking Through the Invisible Boundaries of Global Business. 2014. New York, NY: PublicAffairs.

- Cited Here

30. Hofstede GH. Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations Across Nations. 2001. 2nd ed. Newbury Park, CA: Sage.

- Cited Here

31. Mittal R, Elias SM. Social power and leadership in cross-cultural context. J Manag Dev. 2016;35:58–74.

- Cited Here |
- Google Scholar

32. Brosnan C, Turner BS. Brosnan C, Turner BS, eds. Introduction: The struggle over medical knowledge. In: Handbook of the Sociology of Medical Education. 2009:London, UK: Routledge; 1–12.

- Cited Here

33. Reeves S. Ideas for the development of the interprofessional field. J Interprof Care.

2010;24:217–219.

- Cited Here |
- Google Scholar

34. OECD. 2017. Paris, France: OECD Publishing; https://doi.org/10.1787/19991312. Accessed July 3, 2019.

- Cited Here

35. Papanicolas I, Woskie LR, Jha AK. Health care spending in the United States and other high-income countries. JAMA. 2018;319:1024–1039.

- Cited Here |
- Google Scholar

36. Chaufan C. Is the Swiss health care system a model for the United States? Int J Health Serv. 2014;44:255–267.

- Cited Here |
- Google Scholar

37. Chaufan C. What can US single-payer supporters learn from the Swiss rejection of single payer? Int J Health Serv. 2016;46:331–345.

- Cited Here |
- Google Scholar

38. Gaál P, Szigeti S, Csere M, Gaskins M, Panteli D. Hungary: Health System Review. 2011. World Health Organization. Regional Office for Europe.

- Cited Here

39. Ritzlné IK. Is the Hungarian Non-Observed Economy Rooted in Socialism? Paper presented at: International Association for Research in Income and WealthAugust 20–25, 2018Copenhagen, Denmark

- Cited Here

40. Bochatay N, Bajwa NM. Learning to manage uncertainty: Supervision, trust and autonomy in residency training. Sociol Health Illn. 42(S1):145.

- Cited Here |
- Google Scholar

41. Gyorffy Z, Birkas E, Sandor I. Career motivation and burnout among medical students in Hungary—Could altruism be a protection factor? BMC Med Educ. 2016;16:182.

- Cited Here |
- Google Scholar

42. Ashkanasy NM, Trevor-Roberts E, Earnshaw L. The Anglo cluster: Legacy of the British empire. J World Bus. 2002;37:28–39.

- Cited Here |
- Google Scholar

43. Jesuino JC. Latin Europe cluster: From south to north. J World Bus. 2002;37:81–89.

- Cited Here |
- Google Scholar

44. Bakacsi G, Sándor T, András K, Viktor I. Eastern European cluster: Tradition and transition. J World Bus. 2002;37:69–80.

- Cited Here |
- Google Scholar

45. Danis WM, Shipilov AV. A comparison of entrepreneurship development in two post-communist countries: The cases of Hungary and Ukraine. J Dev Entrep. 2002;7:67–94.

- Cited Here |
- Google Scholar

46. Bochatay N, Bajwa NM, Cullati S, et al. A multilevel analysis of professional conflicts in health care teams: Insight for future training. Acad Med. 2017;92(11 suppl):S84–S92.

- Cited Here |
- Google Scholar

47. Csupor É, Kuna Á, Pintér JN, Kaló Z, Csabai M. Types of conflicts and conflict management among Hungarian healthcare workers [in Hungarian]. Orv Hetil. 2017;158:625–633.

- Cited Here |
- Google Scholar

48. Kim S, Buttrick E, Bohannon I, Fehr R, Frans E, Shannon SE. Conflict narratives from the health care frontline: A conceptual model. Confl Resolut Q. 2016;33:255277.

- Cited Here |
- Google Scholar

49. Helmich E, Cristancho S, Diachun L, Lingard L. 'How would you call this in English?': Being reflective about translations in international, cross-cultural qualitative research.

Perspect Med Educ. 2017;6:127132.

- Cited Here |
- Google Scholar

50. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. Qual Health Res. 2005;15:1277–1288.

- Cited Here |
- Google Scholar

51. Goffman E. The Presentation of the Self in Everyday Life. 1990. London, UK: Penguin.

- Cited Here

52. Wallenburg I, Bont A, Heineman MJ, Scheele F, Meurs P. Learning to doctor: Tinkering with visibility in residency training. Sociol Health Illn. 2013;35:544–559.

- Cited Here |
- Google Scholar

53. Fackler CA, Chambers AN, Bourbonniere M. Hospital nurses' lived experience of power. J Nurs Scholarsh. 2015;47:267–274.

- Cited Here |
- Google Scholar

54. Creed PA, Searle J, Rogers ME. Medical specialty prestige and lifestyle preferences for medical students. Soc Sci Med. 2010;71:1084–1088.

- Cited Here |
- Google Scholar

55. Bowen JL, O'Brien BC, Ilgen JS, Irby DM, ten Cate O. Chart stalking, list making, and physicians' efforts to track patients' outcomes after transitioning responsibility. Med Educ. 2018;52:404–413.

- Cited Here |
- Google Scholar

56. Dow AW, Zhu X, Sewell D, Banas CA, Mishra V, Tu SP. Teamwork on the rocks: Rethinking interprofessional practice as networking. J Interprof Care. 2017;31:677–678.

- Cited Here |
- Google Scholar

57. Garman AN, Leach DC, Spector N. Worldviews in collision: Conflict and collaboration across professional lines. J Organ Behav. 2006;27:829–849.

- Cited Here |
- Google Scholar

58. Simpkin AL, Armstrong KA. Communicating uncertainty: A narrative review and framework for future research. J Gen Intern Med. 2019;34:2586–2591.

- Cited Here |
- Google Scholar

59. Edmondson A. Psychological safety and learning behavior in work teams. Admin Sci Quart. 1999;44:350–383.

- Cited Here |
- Google Scholar

60. Bainbridge L, Regehr G. Orchard C, Bainbridge L, eds. Should there be an "I" in team? A new perspective on developing and maintaining collaborative networks in health professional care. In: Interprofessional Client-Centred Collaborative Practice: What Does It Look Like? How Can It Be Achieved?. 2015:New York, NY: Nova Science Publishers; 51–66.

- Cited Here

61. Mason-Bish H. The elite delusion: Reflexivity, identity and positionality in qualitative research. Qual Res. 2019;19:263–276.

- Cited Here |
- Google Scholar

View full references list

Supplemental Digital Content

- ACADMED_2020_07_13_BOCHATAY_AcadMed-D-19-01743_SDC1.pdf; [PDF] (108 KB)

Copyright © 2020 by the Association of American Medical Colleges

Hide full article text

Related Articles

Myth	Reality
1. For teams to be effective and collaborative, team members need to avoid conflict. The most effective teams are those whose members are friends, are nice to each other, and cooperative.	1. Evidence indicates that teams do not need to avoid conflict to be effective but can embrace and harness conflict to their benefit. Being friends or being nice to one another (while often preferred) is not essential to a team's efficacy and performance.[21,34]
2. In health care, teams are stable entities in which members need to get to know and understand each other to function together effectively.	2. In health care, teams have become unstable, complex, task-oriented groupings of individuals who often do not know each other but have been assembled temporarily to accomplish specific tasks or objectives. The way such teams work has been variously referred to as knotworking, meshworking, teeming, or swarming.[7,67] Whether these unstable, task-oriented teams are more effective than traditional stable teams has not been clearly established.[31]
3. There are clearly established and assessable competencies in the health professions to guide trainees with regard to expectations related to collaboration and teamwork.	3. Competencies in collaboration and teamwork are poorly defined; it is not clear how to most effectively acquire, develop, or assess these competencies.[44,45]
4. Teams generally perform better and are more effective than individuals in achieving goals and completing tasks.	4. Individuals can be more effective than teams, depending on the individual, context, and task (or tasks) at hand.[15,16,45]
5. Conflict on teams should always be resolved, preferably as swiftly as possible, to ensure the effective functioning of the team and to maintain collegial, professional relationships.	5. Conflict on teams does not need to be resolved but can be embraced and integrated to serve the interests of the team, stimulate learning and innovation, and improve performance.[7,21,34]
6. The dynamics of collaboration and teamwork are generalizable across cultures and contexts.	6. The dynamics of collaboration and teamwork are context and culture dependent and are not readily generalizable across contexts and cultures.[8–10]
7. As health professionals, we can readily assess an individual's capacity to collaborate and work on teams.	7. As health professionals, we cannot readily determine and assess an individual's capacity to collaborate and work on teams as these depend on both the context and individual attributes.[44,45]
8. Interprofessional teams are generally more collaborative than discipline-specific teams and best demonstrate the value of teamwork.	8. Interprofessional teams have their own power dynamics, are not free of conflict, and are not always intrinsically collaborative.[68]
9. Most conflicts on teams and in collaborations are due to substantial differences in understandings, perspectives, and opinions, which is why they are so difficult to manage, resolve, or integrate.	9. Most conflicts on teams and in collaborations are quite likely due to relatively minor differences and ought, therefore, to be more amenable to being managed, resolved, or integrated.[31,77,78]
10. Power hierarchies in the health professions are inevitable and necessary to maintain effective chains of command, enhance communication, and improve patient safety.	10. Power hierarchies may not be essential in the health professions; to the contrary, they may obstruct effective communication and decrease patient safety. We, as health professionals, might instead consider democratizing such hierarchies.[17,40,52]

-

Collaboration and Teamwork in the Health Professions: Rethinking the Role of Conflict

April 2018

ACADEMIC MEDICINE
AAMC
Tomorrow's Doctors, Tomorrow's Cures®
Journal of the Association of American Medical Colleges
June 2019
Volume 94
Number 6
In This Issue:
757 Reflections on the Relationship Between Transparency and Trust
781 Competency-Based Curriculum Development to Meet the Needs of People With Disabilities
813 Advancing Population Health at Academic Medical Centers
847 The Relationship Between Board Certification and Disciplinary Actions Against Board-Eligible Family Physicians
869 Residency Program Factors Associated With Depressive Symptoms in Internal Medicine Interns
academicmedicine.org
academicmedicineblog.org
@AcadMedJournal

-

Turning Away From Industrial Health Care Toward Careful and Kind Care

June 2019

ACADEMIC MEDICINE

AAMC

Journal of the Association of American Medical Colleges

September 2023
Volume 98
Number 9

In This Issue

- Artificial Intelligence
- Medical School Admissions
- Residency Selection
- Holistic Review
- Health Professions Workforce
- Health Equity

From Battles to Burnout: Investigating the Role of Interphysician Conflict in Physician Burnout

September 2023

Characteristics	Respondents[b] (n = 3,395)	Overall sample (N = 5,992)
Male sex, no. (%)	1,428 (49)	3,049 (51)
Age, no. (%)		
< 25	994 (34)	1,733 (29)
25–30	1,663 (56)	3,686 (62)
31–35	214 (7)	461 (8)
36–40	63 (2)	78 (1)
> 40	24 (1)	32 (1)
Year of medical school, no. (%)		
Year 1	722 (24)	1,454 (24)
Year 2	731 (25)	1,432 (24)
Year 3	666 (23)	1,452 (24)
Year 4	765 (26)	1,441 (24)
Other	68 (2)	213 (4)

[a]Numbers in each column may not sum to the total for that column because of missing data. Data for the overall sample were obtained from institutional records.
[b]Percentage calculations are not all based on a denominator of 3,395 because of missing responses to some survey items.

-

Role Modeling and Regional Health Care Intensity: U.S. Medical Student Attitudes Toward and Experiences With Cost-Conscious Care

May 2017

Benefits and opportunities	Fears and risks
Rapid communication of research (preprints take 1–2 days to post, whereas peer-reviewed articles typically take approximately 180 days to publish in medical education)	Some journals do not accept work that has been preprinted
Broad and unrestricted access; free to post and read	Flawed preprint studies could get cited, thus corrupting the literature base
Opportunities for early feedback from a wider community of reviewers and stakeholders	Invalid research could be shared on social media or covered in the news, spreading misinformation
Stake a claim; establish priority of discovery	Potential to get "scooped" by other scholars
Demonstrate progress or productivity (e.g., listing preprints on a curriculum vitae, grant proposal)	Copyright and licensing concerns (e.g., conflicts with patent applications)
A place to share results with no other appropriate home (e.g., null results); potential to help address publication bias in the scholarly literature	Potential misuse by interest groups (e.g., pharmaceutical companies) to promote their own agendas
Added visibility in the scholarly literature and online media (i.e., an altmetrics advantage and a citation advantage)	Flawed results could be acted on by clinical and educational stakeholders, potentially causing harm to health, well-being, or learning

-

Preprints in Health Professions Education: Raising Awareness and Shifting Culture

January 2023

Responsibilities of the CWO[a]	Measures and evidence of organizational progress[b]
Measure well-being, burnout, and professional fulfillment across the organization	Rates of burnout, professional fulfillment across the organization
Measure the efficiency of the practice environment and identify opportunities to improve it	Efficiency of the practice environment (amount of time spent on documentation or turnaround times, among others)
Engage members of the organization while working to create the optimal practice environment	Efficiency of the practice environment (amount of time spent on documentation or turnaround times, among others)
Assess the organizational culture and identify dimensions of culture that require strengthening	Strengthening and addressing issues related to organizational culture
Provide relevant and actionable data to other leaders	Leaders who act to drive improvements in their spheres of influence and responsibility
Develop an organization-wide action plan for improving clinician well-being	Implementation of an organization-wide action plan to improve clinician well-being
Determine what resources are necessary, advocate for those resources, and develop a business case and a path to secure those resources	Allocation of resources to promote clinician well-being
Identify hot spots and provide guidance, recommendations, tactics, and support to those areas	Implementation of suggested tactics and improvement processes
Develop system-wide resources for individuals to improve well-being	Provision of funding and the infrastructure needed to offer resources for individuals to improve well-being
Develop system-wide resources to support individuals in distress	Provision of funding and creation of the infrastructure needed to offer resources to support individuals in distress
Develop system-wide resources to help leaders develop behaviors that promote the well-being of those they lead	Provision of funding and creation of the infrastructure needed to help leaders develop behaviors that promote the well-being of those they lead
Advocate for clinician well-being in organizational decision making	Taking clinician well-being into account when making organizational decisions
Influence other leaders' thinking and sense of shared ownership of clinician well-being	All leaders feel responsible and accountable for clinician well-being across their organization

[a]Responsibility of the CWO and his or her team; CWO is accountable.
[b]Responsibility of senior leaders in the organization; all senior leaders are accountable.

The Health Care Chief Wellness Officer: What the Role Is and Is Not

September 2020

^Back to Top

Never Miss an Issue

Get new journal Tables of Contents sent right to your email inbox Type your email

Get New Issue Alerts

Browse Journal Content

- Most Popular
- For Authors
- About the Journal
- Past Issues
- Current Issue
- Register on the website

- Subscribe
- Get eTOC Alerts

For Journal Authors

- Submit an article
- How to publish with us

Customer Service

- Activate your journal subscription
- Activate Journal Subscription
- Browse the help center
- Help
- Contact us at:
  - Support:
    Submit a Service Request
  - TEL: (USA):
    TEL: (Int'l):
    800-638-3030 (within USA)
    301-223-2300 (international)
- Manage Cookie Preferences
-
-
-
-
-

- Privacy Policy
- Legal Disclaimer
- Terms of Use
- Open Access Policy
- Feedback
- Sitemap
- RSS Feeds
- LWW Journals
- Your California Privacy Choices
- Copyright © 2024
- by the Association of American Medical Colleges